PA09-2002: BOTOX REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

FAX TO:
DEPARTMENT OF HUMAN SERVICES
ATTN: PHARMACIST
401-462-6336

CLIENT NAME _____ DOB: _____ MEDICAID ID CARD NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER PROVIDER #: _____

PRESCRIBER OFFICE ADDRESS: _____

_____

OFFICE PHONE NUMBER ( ) _____- _____

REQUESTER NAME: _____ RN /MD /R.PH / _____

PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____

DRUG REQUESTED _____ STRENGTH _____

REQUEST TYPE (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE _____ UNITS / RX _____

DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) DOSING FREQUENCY: _____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-9 CODE.

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

DIAGNOSIS: **ICD9 CODE:**

IS RECIPIENT RECEIVING MEDICATION THROUGH PRESCRIBER? _____YES _____NO

IF YES, WHAT IS THE J CODE? _____

IS RECIPIENT RECEIVING MEDICATION AT PHARMACY? _____YES _____NO

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____ **APPROVED**_____

DENIED _____ **REASON**_____

ADDITIONAL INFORMATION REQUIRED _____

_____

DATE RESPONSE _____

REVIEWER _____

COMMENTS: